STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was in conjunction to the Investigation of Complaint IN00148896. Survey dates: June 1, 2, 3, 4, 5, 6, 9, and 10, 2014 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN Karyn Homan, RN Patsy Allen, SW (June 1, 2, 3, 4, 6, 9, and 10, 2014) Census bed type: SNF/NF: 67 Residential: 69 Total: 136 Census payor type: Medicare: 20 Medicaid: 33 Other: 83 Total: 136	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited ir accordance with 410 IAC 16.2-3.1. Quality Review completed on June 17, 2014; b Kimberly Perigo, RN.			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review, and interview, the facility failed to ensure a care plan was accurate and updated for a resident who was injured during a surface	F000280	Date: 6/20/2014 Tag # F 280 SS=D Right to participate planning care Description of findings: The facility failed to ensure a care plan was accurate and updated for a resident who was injured during a surface to	07/10/2014

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	to surface transfer. (Resident #A) Findings include: The clinical record of Resident #A was reviewed on 6/5/14 at 10:00 a.m. Diagnoses included, but were not limited to, muscle weakness, difficulty walking, and dementia. A quarterly Minimum Data Set assessment, dated 1/30/14, and an annual Minimum Data Set dated 5/7/14, both indicated Resident #A was severely cognitively impaired and needed extensive assistance of 2 people for transferring. A care plan for Resident #A, dated 4/28/12, and current through 8/21/14, indicated she was at risk for falls related to impaired mobility and dementia. The goal was she would remain free from injury. Approaches were, bed in low position (initiated 1/23/14), encourage resident to assume a standing position slowly (initiated 4/28/12), give resident verbal reminders not to ambulate/transfer without assistance (initiated 4/28/12), keep call light and personal items within reach (initiated 4/28/12), and provide toileting assistance per resident's needs (initiated 4/28/12).		surface transfer. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #A care plan and staff's assignment sheets checked to assure the proper level of assistance needed for transfers is accurate. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 1. Residents who require the assistance of healthcare workers for transfers have the potential to be affected. The care plans and nurse aide assignment sheets have been audited for those residents who need assistance with transfers and the care plans and nurse aide assignment sheets reflect the correct assistance staff needs to provide to ensure safe transfers are happening. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. Employees will be in-serviced and checked off on safe and effective transfer techniques. 2. Unit managers/or designee will audit 4 transfers, randomly on all shifts 7 days per week, weekly for 60 days and upon completion will audit 4 transfers, randomly on all shifts 7 per week, every thirty days. 3. All new hires will receive transfer training with return demonstration	

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	A care plan for Resident #A, dated 5/9/12, and current through 8/21/14, indicated she required extensive assist with most activities of daily living related to weakness, impaired mobility, and cognitive deficits. Approaches included, side rails (on both sides of the bed) up to assist with bed mobility/positioning, transfers, transfer with assist of 1 (staff person) using gait belt for safety. All approaches were initiated 5/9/12. An Incident Report Form, dated 5/7/14, sent by the facility to the Indiana State Department of Health, indicated on 5/6/14 at 6:30 p.m., a Certified Nursing Assistant (CNA) was transferring Resident #A from her wheelchair to her bed. During the transfer, the resident received a 14 centimeter (cm) laceration (irregular tear of the skin) to her left lower leg. The laceration was cleaned and covered, and Resident #A was sent to an emergency room for evaluation and treatment. The report indicated the resident received 24 staples (a means of fastening tissue/skin to another) to the area of the laceration on her left lower leg. The report indicated the resident's transfer program, plan of care, and assignment sheet were reviewed. During an observation on 6/2/14 at 1:00 p.m., Resident A's right leg had a		check offs. 4. Director of nursing or designee will audit 3 different transfers randomly on all shifts 7days per week, weekly for 60 days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. All audits will be brought to QA for a minimum of 120 days. 2. A minimum threshold of 95% accuracy will be expected on the transfer technique audit tools used or additional corrective actions will be put into place until the goal is met. 3. The administrator/or designee will ensure compliance. By What date the systemic changes will be completed? 7/10/2014	

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	dressing on it. During an interview with Unit Manager #1 and the Director of Nursing, on 6/6/14 at 11:30 a.m., Unit Manager #1 indicated it was Resident #A's right leg, not her left leg, which received the skin laceration. A nurse's note, dated 5/6/14 at 6:30 p.m., indicated, "...called to the room per CNA. CNA reported resident had a skin tear and was bleeding. Upon entering the resident's room, signee observed resident in bed and her right LE [lower extremity] was bleeding from a [large] laceration. ....assessed the area, reported to MD [medical doctor] on unit [MD observed], Laceration is 16 cm in length, 3 cm open with 6 cm skin flap, muscle visible...Resident continues to have...bleeding from laceration. Resident denies pain and is asking questions of what happened and what was wrong. Staff reassured resident." A nurse's note dated 5/6/14 at 6:36 p.m., indicated an ambulance was called as the physician wanted the resident to be evaluated in the emergency room. A nurse's note dated 5/6/14 at 7:00 p.m., indicated the resident was transported to the hospital. A nurse's note dated 5/6/14 at 10:33 p.m. indicated Resident #A returned from the			

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	hospital at 10:10 p.m. The note indicated, "She has 24 staples in place to RLE [right lower extremity], that need to be removed in 14 days...." Review of an Associate Warning Notice, provided by the Director of Nursing on 6/2/14 at 3:10 p.m., indicated, "Employee transferred resident as 1 person assist when assignment sheet states 2 person." During an interview with Unit Manager #1 on 6/5/14 at 3:00 p.m., she indicated CNA #2 should have used 2 people to transfer Resident #A on 5/6/14. She indicated the resident was inconsistent in her ability to assist with transfers and that was why they made Resident #A, "A 2 person transfer." Review of Resident #A's current care plans dated 4/28/12 and 5/9/12, the care plans did not indicate Resident #A was a 2 person transfer. Further information regarding why her need for a 2 person transfer was not careplanned was requested from the DON on 6/5/14 at 3:00 p.m. No further information was provided by survey exit on 6/9/14 at 11:15 a.m. This Federal tag relates to Complaint IN00148896.			

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	3.1-35(d)(2)(B)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure physician's orders for warfarin, a blood thinner, were clearly written on the medication administration record (MAR) for 1 of 14 residents reviewed for correct medication administration, which resulted in a medication administration error. (Resident #156) Findings include: The clinical record of Resident #156 was reviewed on 6/5/14 at 9:30 a.m. Resident #156 was admitted to the facility on 6/1/14. Diagnoses included, but were not limited to, cholelithiasis (gall stones) with acute cholecystitis (inflammation of the gall bladder), congestive heart failure, hypertension, atrial fibrillation, and iron deficiency anemia. During an observation of medication	F000309	Date: 6/20/2014 Tag # F 309 SS=D Provide care/services for highest wellbeing. Description of findings: The facility failed to ensure physician's orders for warfarin, a blood thinner, were clearly written on the MAR for 1 of 14 residents reviewed for correct med administration, which resulted in a medication error. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Coumadin orders for resident #156 were immediately corrected, Physician and family notified, resident #156 is receiving the proper dose of Coumadin. 2. Resident #156 was assessed and no abnormal finding from the deficient practice, lab work was performed to ensure the residents' therapeutic levels are appropriate. Lab report shown normal levels. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be	07/10/2014

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	administration on Wednesday, 6/4/14 at 4:07 p.m., Licensed Practical Nurse (LPN) #1 was observed administering warfarin 5 mg (milligrams) to Resident #156. During a review of the recapitulation of physician's orders for Resident #156 on 6/5/14 at 9:30 a.m., the warfarin order indicated, "Take 2.5 mg PO (by mouth) Monday Wednesday and Friday. Take 5 mg PO Tuesday Thursday Saturday and Sunday." A review of the MAR (Medication Administration Record) for Resident #156, indicated Resident #156 had warfarin administered on 6/2, 6/3, and 6/4/14 (Monday, Tuesday, and Wednesday). The documentation of the administration of warfarin included staff initials. The dosage of the warfarin administered was not included/indicated in the documentation. During an interview with the Director of Nursing (DON) on 6/5/14 at 11:15 a.m., the DON indicated the order for warfarin should have been entered onto the MAR as two separate administrations, one for each dosage. The DON indicated Resident #156 should have received 2.5 mg of warfarin on 6/4/14, when warfarin 5 mg was administered. On 6/5/14 at 9:30 a.m., the DON		taken? 1. All resident s who receive medications have the potential to be affected by this deficient practice. 2. All Physicians orders will be read and checked in Morning clinical meeting by the Unit managers/or designee. 3. Medication orders will also be verified monthly to ensure no duplicate orders exist. 4. Medication pass audits/check off will be completed on all Licensed staff and continued monitoring with 4 audits randomly on all shifts 7 days per week for 90 days. 5. Medications audits will then be completed on all staff quarterly continuously. 6. The director of nursing or designee will be responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 7. All Physicians orders will be read and checked in Morning clinical meeting by the Unit managers/or designee. 8. Medication orders will also be verified monthly to ensure no duplicate orders exist. 9. Medication pass audits/check off will be completed on all Licensed staff and continued monitoring with random 4 audits per week, including all shifts 7 days per week for 90 days. 10. Medications audits will then be completed on all staff quarterly continuously. 11. The director of nursing or designee will be responsible to ensure	

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	provided an undated policy titled, "Medication Administration: General Policies & Procedures," and indicated the policy was the one currently used by the facility. The policy indicated "...Medications are administered as prescribed in accordance with good nursing principals and practices...." 3.1-37(a)		compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. All audits will be brought to QA for a minimum of 120 days. 2. The administrator or designee will ensure compliance. What date the systemic changes will be completed? 7/10/2014	
F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was safely transferred from one surface to another, which resulted in the resident receiving a 14 centimeter skin tear to her leg, a trip to the emergency room, and 24 staples to close the wound, for 1 of 3 residents reviewed for accidents. (Resident #A) Findings include: The clinical record of Resident #A was reviewed on 6/5/14 at 10:00 a.m.	F000323	Date: 6/20/2014 Tag # F 323 SS=G Free of accident hazards/supervision/devices Description of findings: The facility failed to ensure a resident was safely transferred from one surface to another, which resulted in the resident receiving a 14 cm skin tear to her leg, a trip to the ER, and 24 staples to close the wound, for 1 of 3 residents reviewed. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #A care plan and staff's assignment sheets checked to assure the proper level of assistance needed	07/10/2014

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	Diagnoses included, but were not limited to, muscle weakness, difficulty walking, and dementia. A quarterly Minimum Data Set assessment, dated 1/30/14, and an annual Minimum Data Set dated 5/7/14, both indicated Resident #A was severely cognitively impaired and needed extensive assistance of 2 people for transferring. An Incident Report Form, dated 5/7/14, sent by the facility to the Indiana State Department of Health, indicated on 5/6/14 at 6:30 p.m., a Certified Nursing Assistant (CNA) was transferring Resident #A from her wheelchair to her bed. During the transfer, the resident received a 14 centimeter (cm) laceration (irregular tear of the skin) to her left lower leg. The laceration was cleaned and covered, and Resident #A was sent to an emergency room for evaluation and treatment. The report indicated the resident received 24 staples (a means of fastening tissue/skin to one another) to the area of the laceration on her left lower leg. The report indicated the resident's transfer program, plan of care, and assignment sheet were being reviewed, the bed was padded, cognitively intact residents on the unit were being interviewed regarding their transfers, and		for transfers is accurate. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 1. Residents who require the assistance of healthcare workers for transfers have the potential to be affected. The care plans and nurse aide assignment sheets have been audited for those residents who need assistance with transfers and the care plans and nurse aide assignment sheets reflect the correct assistance staff needs to provide to ensure safe transfers are happening. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. Employees will be in-serviced and checked off on safe and effective transfer techniques. 2. Unit managers/or designee will audit 4 random transfers on all shifts 7 days per week for 60 days and upon completion will audit 4 random transfers, all shifts 7 days per week every thirty days. 3. All new hires will receive transfer training with return demonstration check offs. 4. Director of nursing or designee will audit 3 random transfers, including all shifts 7 days per week for 60 days . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	the CNA was suspended pending investigation. During an observation on 6/2/14 at 1:00 p.m., Resident A's right leg had a dressing on it. During an interview with Unit Manager #1, and the Director of Nursing, on 6/6/14 at 11:30 a.m., Unit Manager #1 indicated it was Resident #A's right leg, not her left leg, which received the skin laceration. A nurse's note, dated 5/6/14 at 6:30 p.m., indicated, "...called to the room per CNA. CNA reported resident had a skin tear and was bleeding. Upon entering the resident's room, signee observed resident in bed and her right LE [lower extremity] was bleeding from a [large] laceration. ....assessed the area, reported to MD [medical doctor] on unit [MD observed], Laceration is 16 cm in length, 3 cm open with 6 cm skin flap, muscle visible...Resident continues to have...bleeding from laceration. Resident denies pain and is asking questions of what happened and what was wrong. Staff reassured resident." A nurse's note dated 5/6/14 at 6:36 p.m., indicated an ambulance was called as the physician wanted the resident to be evaluated in the emergency room. A nurse's note dated 5/6/14 at 7:00 p.m.,		program will be put into place? 1. All audits will be brought to QA for a minimum of 120 days. 2. A minimum threshold of 95% accuracy will be expected on the transfer technique audit tools used or additional corrective actions will be put into place until the goal is met. 3. The administrator or designee will ensure compliance. By What date the systemic changes will be completed? 7/10/2014	

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	indicated the resident was transported to the hospital. A nurse's note dated 5/6/14 at 10:33 p.m. indicated Resident #A returned from the hospital at 10:10 p.m. The note indicated, "She has 24 staples in place to RLE, [right lower extremity] that need to be removed in 14 days...." Review of an Associate Warning Notice, provided by the Director of Nursing on 6/2/14 at 3:10 p.m., indicated, "Employee transferred resident as 1 person assist when assignment sheet states 2 person." During an interview with CNA #2 on 6/4/14 at 3:30 p.m., she indicated Resident #A had been assigned to her on the evening shift, 5/6/14. CNA #2 indicated she wasn't really sure how Resident #A got her skin tear. She indicated her assignment sheet on 5/6/14, evening shift said Resident #A was a 2 person transfer, but she did not enlist the help of another staff person to transfer the resident. During an interview with the Director of Nursing on 6/2/14 at 3:00 p.m., she indicated she wasn't really sure what caused the laceration on Resident #A's leg, but CNA #2 should have used 2 people to transfer the resident.			

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	During an interview with Unit Manager #1 on 6/5/14 at 3:00 p.m., she indicated CNA #2 should have used 2 people to transfer Resident #A on 5/6/14. She indicated the resident was inconsistent in her ability to assist with transfers and that was why they made Resident #A, "A 2 person transfer." This Federal tag relates to Complaint IN00148896. 3.1-45(a)(2)			
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to assure 66 of 67 residents, who ate food prepared in the kitchen, received food prepared, distributed, and served under sanitary conditions. Finding include: During the service of evening meal on 06-01-14 at 4:55 p.m., the following were observed:	F000371	6/20/2014 F371 SS=E Store/Prepare/ Serve-Sanitary Findings= Facility failed to assure 66 of 67 residents , who ate food prepared in the kitchen, received food prepared, distributed and served under sanitary conditions. **1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** a. The residents have been assessed and no residents were identified as being negatively affected by the	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	06/10/2014

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	1) Dietary Staff # 1 was observed on the service line to handle the bread with gloved hands when preparing chicken salads sandwiches. After staff had handled the serving trays, the plates, ketchup bottle, lettuce, tomato, cheese, handle of the scoop use to get the chicken salad, and handled plate covers for the room trays. Same staff was observed a few minutes later handling the buns for hamburgers/cheeseburgers with same gloved hands. Dietary Staff # 1 went out of the kitchen came back in the kitchen touching the door both times and did not change gloves. Dietary Staff # 1 placed gloved hand into a large bag of potato chips and then placed the chips on the residents plates. Dietary staff # 1 did remove gloves after finishing the trays for C-Hall and placed on more gloves, without washing hands. Dietary Staff # 1 was observe to wear a beard cover, but leaving his mustache uncovered while preparing and serving the meal. On 6-10-14 at 9:00 a.m., the Administrator provided the Policy 9.1 Environmental Sanitation/Infection		deficient practice(s). **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** a. All other residents have the potential to be affected by the deficient practice(s). b. The dietary staff and other facility staff will be in serviced on the environmental sanitation and infection control policy to cover areas such as; proper gloving, when to remove gloves, touching environmental surfaces and when to wash hands, covering facial hair fully with sanitary covers and other sanitary practices that are the policy of the Altenheim. c. Teflon skillets showing signs of wear have been replaced with new pans. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur;** a. The dietary staff and other facility staff will be in serviced on the environmental sanitation and infection control policy to cover areas such as; proper gloving, when to remove gloves, touching environmental surfaces and when to wash hands, covering facial hair fully with sanitary covers and other sanitary practices that are the policy of the Altenheim. b. Teflon skillets showing signs of wear have been replaced with new pans. c. A CQR audit will be conducted auditing the proper	

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	Control, dated 2012, and indicated the policy was the one currently used by the facility. The policy indicated, "... A hair restraint that effectively cover head and /or facial hair (moustache and/or beard), is worn in the food preparation areas. Hair is arranged to prevent contamination food equipment and utensils...." 2) Dietary Staff # 2 was observed to get a skillet, butter, bread, cheese, and handle a spatula. Then prepare grilled cheese sandwiches, without washing hands or changing gloves. On 6-10-14 at 9:00 a.m., the Administrator provided the Policy 9.62 Environmental Sanitation/Infection Control dated 2012, and indicated the policy was the one currently used by the facility. On 6-10-14 at 9:30 a.m., review of Policy 9.62 Environmental Sanitation /Infection Control dated 2012. Under Procedure: "... 2. hands are always washed prior to putting on gloves. When donning gloves, minimal contact is made with the surfaces that will come in actual contact with the food such as the fingers. Gloves come in a variety of sizes so that they fit individual staff. 3. Disposable gloves are used to perform single task such as preparing sandwiches		sanitation techniques of staff, hand washing audits, equipment audits, proper gloving techniques and other proper safe and effective sanitation expectations to ensure compliance is met. The dietary manager or designee will randomly audit meals to include all meal times 7 days per week to ensure compliance weekly x 4 weeks, monthly x 2 months and quarterly thereafter. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a. All audits will be brought to QA for a minimum of 120 days. b. The administrator or designee will ensure compliance. **5. By what date the systemic changes will be completed.** a. July 10,2014	

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	thy are then discarded to prevent cross-contamination 5. gloves are discarded when they are contaminated in any way. contamination can occur when touching unclean surfaces such as a refrigerator handle, trash can, contact with bodily fluids (such as from sneezing or coughing) or if they become torn...." 3) ON 06-06-14 at 1:10 a.m., During sanitation tour with the Dietary Manager three (3) of five (5) Teflon skillets had damaged or missing Teflon. On 06-01-14 at 4:55 p.m., Dietary Staff # 2 prepared the grilled cheese sandwiches in a skillet where the Teflon had scratches, peeling Teflon, or the Teflon was gone. During an interview with the Dietary Manager on 6-10-14 at 10: 30 a.m., she indicated the staff receive training and policies are gone over during orientation, and staff receive miniseries and protocol update through the duration of their employment. 3.1-21(i)(3)			

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R000000	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction to the Investigation of Complaint IN00148896. Survey dates: June 1, 2, 3, 4, 5, 6, 9, and 10, 2014 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN Karyn Homan, RN Patsy Allen, SW (June 1, 2, 3, 4, 6, 9, and 10, 2014) Census bed type: SNF/NF: 67 Residential: 69 Total: 136 Census payor type:	R000000		

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	Medicare: 20 Medicaid: 33 Other: 83 Total: 136 Residential sample: 8 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 17, 2014; by Kimberly Perigo, RN.			
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to ensure 69 of 69 residents, who ate food prepared in the kitchen, received food prepared, distributed, and served under sanitary conditions. Finding include: During the service of evening meal on 06-01-14 at 4:55 p.m., the following were observed: 1) Dietary Staff # 1 was observed on the	R000273	6/20/2014 R 273 Store/Prepare/ Serve-Sanitary Findings= Facility failed to assure 69 of 69 residents , who ate food prepared in the kitchen, received food prepared, distributed and served under sanitary conditions. **1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** a. The residents have been assessed and no residents were identified as being negatively affected by the deficient practice(s). **2. How other residents having the**	07/10/2014

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	service line to handle the bread with gloved hands when preparing chicken salads sandwiches. After staff had handled the serving trays, the plates, ketchup bottle, lettuce, tomato, cheese, handle of the scoop use to get the chicken salad, and handled plate covers for the room trays. Same staff was observed a few minutes later handling the buns for hamburgers/cheeseburgers with same gloved hands. Dietary Staff # 1 went out of the kitchen came back in the kitchen touching the door both times and did not change gloves. Dietary Staff # 1 placed gloved hand into a large bag of potato chips and then placed the chips on the residents plates. Dietary staff # 1 did remove gloves after finishing the trays for C-Hall and placed on more gloves, without washing hands. Dietary Staff # 1 was observe to wear a beard cover but leaving his mustache uncovered while preparing and serving the meal. On 6-10-14 at 9:00 a.m., the Administrator provided the Policy 9.1 Environmental Sanitation/Infection Control, dated 2012, and indicated the		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** a. All other residents have the potential to be affected by the deficient practice(s). b. The dietary staff and other facility staff will be in serviced on the environmental sanitation and infection control policy to cover areas such as; proper gloving, when to remove gloves, touching environmental surfaces and when to wash hands, covering facial hair fully with sanitary covers and other sanitary practices that are the policy of the Altenheim. c. Teflon skillets showing signs of wear have been replaced with new pans. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur;** a. The dietary staff and other facility staff will be in serviced on the environmental sanitation and infection control policy to cover areas such as; proper gloving, when to remove gloves, touching environmental surfaces and when to wash hands, covering facial hair fully with sanitary covers and other sanitary practices that are the policy of the Altenheim. b. Teflon skillets showing signs of wear have been replaced with new pans. c. A CQR audit will be conducted auditing the proper sanitation techniques of staff, hand washing audits, equipment	

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	policy was the one currently used by the facility. The policy indicated, "... A hair restraint that effectively cover head and /or facial hair (moustache and/or beard), is worn in the food preparation areas. Hair is arranged to prevent contamination food equipment and utensils...." 2) Dietary Staff # 2 was observed to get a skillet, butter, bread, cheese, and handle a spatula. Then prepare grilled cheese sandwiches without washing hands or changing gloves. On 6-10-14 at 9:00 a.m., the Administrator provided the Policy 9.62 Environmental Sanitation /Infection Control dated 2012, and indicated the policy was the one currently used by the facility. On 6-10-14 at 9:30 a.m., review of Policy 9.62 Environmental Sanitation /Infection Control dated 2012. Under Procedure: "... 2. hands are always washed prior to putting on gloves. When donning gloves, minimal contact is made with the surfaces that will come in actual contact with the food such as the fingers. Gloves come in a variety of sizes so that they fit individual staff. 3. Disposable gloves are used to perform single task such as preparing sandwiches thy are then discarded to prevent		audits, proper gloving techniques and other proper safe and effective sanitation expectations to ensure compliance is met. The dietary manager or designee will conduct random audits at all different meal times 7 days a week to ensure compliance, weekly x 4 weeks, monthly x 2 months and quarterly thereafter. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** a. All audits will be brought to QA for a minimum of 120 days. b. The administrator/or designee will ensure compliance. **5. By what date the systemic changes will be completed.** a. July 10,2014	

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	cross-contamination 5. gloves are discarded when they are contaminated in any way. contamination can occur when touching unclean surfaces such as a refrigerator handle, trash can, contact with bodily fluids (such as from sneezing or coughing) or if they become torn...." 3) ON 06-06-14 at 1:10 a.m., During sanitation tour with the Dietary Manager three (3) of five (5) Teflon skillets had damaged or missing Teflon. On 06-01-14 at 4:55 p.m., Dietary Staff # 2 prepared the grilled cheese sandwiches in a skillet where the Teflon had scratches, peeling Teflon, or the Teflon was gone. During an interview with the Dietary Manager on 6-10-14 at 10: 30 a.m., she indicated the staff receive training and policies are gone over during orientation, and staff receive miniseries and protocol update through the duration of their employment.			
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be			

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	155196	A. BUILDING 00 B. WING	06/10/2014

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	maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records contained results for laboratory specimens ordered by the physician for 3 of 8 residents reviewed for having complete and accurate clinical records. (Residents #438, #452, and #405) Findings include: 1. The clinical record of Resident #438 was reviewed on 6/9/14 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, depression and high blood pressure. A physician's order, dated 3/21/14, indicated the facility was supposed to obtain a stool specimen from the resident to check for Clostridium difficile. (C-diff) This is a bacterium which can cause symptoms ranging from diarrhea to life threatening inflammation of the colon. It can develop after the use of antibiotic medication. The resident had been taking an antibiotic for a wound on her ankle from 3/6/14 to 3/18/14.	R000349	Date: 6/20/2014 Tag # R349 Clinical Records/noncompliance Description of findings: The facility failed to ensure clinical records contained results for laboratory specimen's ordered by the physician for 3 of 8 residents reviewed for having complete and accurate clinical records. (Residents # 438, # 452 and # 405) What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Lab orders for resident #438, 452 and 405 were immediately called to Physician and family notified and to Laboratory. 2. Residents # 438, 452 and 405 were assessed and no abnormal finding from the deficient practice, lab work was performed to ensure the residents' therapeutic levels are appropriate. Labs returned with results within normal limits. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 1. All resident s who have ordered labs have the potential to be affected by this deficient practice and will be	07/10/2014

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	A physician progress note, dated 3/21/14, indicated, "Acute diarrhea several times yesterday. 'Green.' 2 x this a.m...had Keflex (an antibiotic) this month...certainly likely for C-diff." A nurse's note, dated 3/21/14 at 8:13 p.m., indicated the stool specimen was collected and ready for the laboratory to pick up. The note indicated the stool specimen was runny and pale. No results from this laboratory test were found in the resident's record. During an interview with the Unit Manager on 6/9/14 at 12:00 p.m., she indicated the test was not done. She indicated she thought it might have been discontinued, because the resident stopped having loose stools. She indicated she did not have an order to discontinue the test. 2. The clinical record of Resident #452 was reviewed on 6/9/14 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, high blood pressure, depressive disorder, muscle weakness, hypopotassemia (low potassium in the blood) and hyponatremia (low sodium in the blood). A physician's order dated 8/15/13 indicated Resident #452 was supposed to		audited for completion. 2. All Physicians orders will be read and checked in Morning clinical meeting by the Unit managers/or designee. 3. Lab orders will be verified monthly to ensure no duplicate orders exist. 4. The director of nursing or designee will be responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. All Physicians orders will be read and checked in Morning clinical meeting by the Unit managers/or designee. 2. Laboratory orders will also be verified monthly to ensure no duplicate orders exist. 3. Lab results/orders will be tracked by unit manager or designee to ensure completion. 4. The director of nursing or designee will be responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. All audits will be brought to QA for a minimum of 120 days. 2. The administrator or designee will ensure compliance. By What date the systemic changes will be completed? 7/10/2014	

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	have a BMP and a CBC drawn monthly. A BMP is a basic metabolic panel, a blood laboratory tests which measures blood sugar, kidney function, and electrolytes like sodium and potassium. A CBC is a complete blood count which measures white and red blood cells. BMP's were not found in the clinical record for the months of February, March, and April 2014. CBC's were not found in the clinical record for the months of February, March, April, and June 2014. During an interview with the Unit Manager, on 6/9/14 at 12:00 p.m., she indicated she was unable to find any other BMP or CBC lab results since the order was written on 8/15/13. 3. Resident #405's clinical record was reviewed on 6/09/14 at 9:30 a.m. Diagnoses included, but were not limited to, congestive heart failure (inability of the heart to pump enough blood through the body), diabetes (high levels of sugar in the blood), and hypertension (high blood pressure). Readmission physician orders signed 11/19/13, indicated an order for a basic metabolic panel (BMP) (blood test that gives information about the body's			

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	metabolism) lab test every month. No BMP lab test results were found in the clinical record for December 2013, February 2014, March 2014, nor April 2014. During an interview 6/09/14 at 2:30 p.m., the Residential Unit Manager indicated she was unable to locate BMP lab results for December 2013, February 2014, March 2014, nor April 2014. During an interview with the Unit Manager on 6/9/14 at 12:00 p.m., she indicated when lab comes to collect specimens, they write the resident's name and test in a facility lab book. She indicated the facility did not have a specific process for checking to see if labs were drawn, results received, or physician's notified. On 6/10/14 at 9:30 a.m., the Director of Nursing provided the Reports of Lab, X-ray, and Other Diagnostic Examination Policy, dated May 2012, and indicated the policy was the one currently used by the residential facility. The policy indicated, "Lab, X-ray and other diagnostic examinations shall be performed as ordered by the physician. The physician shall be notified of the results, and this information shall be recorded in the resident's medical			

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	record."			